Suicide assisted by two Swiss right-to-die organisations

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ABSTRACT

Background: In Switzerland, non-medical right-to-die organisations such as Exit Deutsche Schweiz and Dignitas offer suicide assistance to members suffering from incurable diseases.

Objectives: First, to determine whether differences exist between the members who received assistance in suicide from Exit Deutsche Schweiz and Dignitas. Second, to investigate whether the practices of Exit Deutsche Schweiz have changed since the 1990s.

Methods: This study analysed all cases of assisted suicide facilitated by Exit Deutsche Schweiz (E) and Dignitas (D) between 2001 and 2004 and investigated by the University of Zurich's Institute of Legal Medicine (E: n = 147; D: n = 274, total: 421). Furthermore, data from the Exit Deutsche Schweiz study which investigated all cases of assisted suicide during the period 1990–2000 (n = 149) were compared with the data of the present study.

Results: More women than men were assisted in both organisations (D: 64%; E: 65%). Dignitas provided more assistance to non-residents (D: 91%; E: 3%; p = 0.000), younger persons (mean age in years (SD): D: 64.5 (14.1); E: 76.6 (13.3); p = 0.001), and people suffering from fatal diseases such as multiple sclerosis and amyotrophic lateral sclerosis (D: 79%; E: 67%; p = 0.013). Lethal medications were more often taken orally in cases assisted by Dignitas (D: 91%; E: 76%; p = 0.000). The number of women and the proportion of older people suffering from non-fatal diseases among suicides assisted by Exit Deutsche Schweiz has increased since the 1990s (women: 52% to 65%, p = 0.031; mean age in years (SD): 69.3 (17.0) to 76.9 (13.3), p = 0.000), non-fatal diseases: 22% to 34%, p = 0.026).

Conclusions: Weariness of life rather than a fatal or hopeless medical condition may be a more common reason for older members of Exit Deutsche Schweiz to commit suicide. The strong over-representation of women in both Exit Deutsche Schweiz and Dignitas suicides is an important phenomenon so far largely overlooked and in need of further study.

Although Switzerland does not specifically permit assisted suicide by statute, article 115 of the Swiss Penal Code allows assistance in suicide provided that the person seeking assistance has decisional capacity and the person assisting is not motivated by reasons of self-interest. Unlike in Oregon, where terminal illness is a prerequisite to assistance,[1] article 115 does not specify any medical preconditions. Because cases of assisted suicide are treated as extraordinary deaths, each case must be investigated by the authorities. Based on article 115, Swiss right-to-die organisations can legally offer aid in dying. The way of committing suicide is usually with a lethal dose of barbiturates (sodium pentobarbital) that has been prescribed by a doctor.[2 3] The Swiss practice of assisted suicide allows assistance in dying using intravenous drips or stomach tubes. The legally critical act is the last step of the procedure, opening the tap of the drip or tube. This last step must always be carried out by the individual wanting to die and this must be attested to by a witness.

In Switzerland, four right-to-die organisations facilitate assisted suicide for their members: Exit Deutsche Schweiz, Exit ADMD (*Association pour le droit de mourir dans la dignité*), Dignitas and Exit International. The Swiss German Exit association was founded in Zurich in 1982, and the Exit organisation for the French-speaking part of Switzerland started in Geneva in the same year. They now have about 50 000 and 10 000 members, respectively. The two much smaller right-to-die organisations, Dignitas and Exit International, were started by break-away groups formerly active in Exit Deutsche Schweiz. Dignitas, founded in Zurich in 1998, has around 5000 members. No membership numbers are available for Exit International, which was formed in 1997.

Exit Deutsche Schweiz was the first organisation to offer assistance in suicide, and since 1992 has provided personal guidance to members who want to die. The service is offered only after an evaluation process which requires that the wish to die is deliberate and stable, the member suffers from a disease with a hopeless prognosis, and the suffering is unbearable or unreasonable disability is present (Exit statutes, article 2).

The other organisations have similar preconditions but in contrast to Exit Deutsche Schweiz and Exit ADMD, both Exit International and Dignitas offer assistance to people not resident in Switzerland.[3 4]

Since no central notification system exists in Switzerland, data on the frequency and extent of assisted suicide are limited; scientific literature on assisted suicide in Switzerland, although still scarce, continues to emerge.[3] An international study on medical end-of-life decisions revealed that the incidence of assisted suicide in 2001 accounted for 0.36% of all deaths in Switzerland and that a right-to-die organisation was involved in 92% of these cases.[5] In 2003, the first study of its kind to explore the actual practices of Exit Deutsche Schweiz examined all their case files from 1990 to 2000. Comparison of these case files with the official records held at the University of Zurich's Institute of Legal Medicine (ILMZ) indicated that notification to the authorities seemed to be complete.[6] To date, no empirical data exist on the

practices of right-to-die organisations providing assistance to people travelling to Switzerland from abroad.

This article presents a study to determine whether there is a difference in the characteristics of people receiving assistance in suicide from Exit Deutsche Schweiz (the largest right-to-die organisation assisting Swiss residents and agreeing to assist non-resident foreigners only in exceptional cases), and Dignitas (the largest right-to-die organisation that openly provides assistance to non-resident foreigners), emphasising demographic and medical differences between the deceased members of the two groups. We then examine whether there are any differences between the two organisations in the actual facilitation of assisted suicide. Finally, we analyse whether Exit Deutsche Schweiz's practices have changed since the previous study.

METHODS

Material

This study is based on an analysis of all reported suicides in Zurich from 2001 to 2004. Data for this study are taken from the medicolegal records kept by the ILMZ, the official body responsible for the investigation of all extraordinary deaths in the city of Zurich (where the majority of Exit Deutsche Schweiz and Dignitas deaths occur). These files contain a structured report by a medicolegal expert together with a record sheet from the right-to-die organisation. Most of the records include additional documents such as a medical report/opinion and/or a note written by the member during the procedures. In addition to sociodemographic and medical characteristics of the deceased, these files provide information on how the suicide was performed.

Variables examined

Characteristics of the deceased: (1) sex; (2) age; (3) marital status; (4) country of residence (resident, non-resident in Switzerland); and (5) medical diagnosis—subdivided into fatal diseases (cancer, cardiovascular/respiratory diseases, neurological diseases, and HIV/AIDS) on the one hand and non-fatal diseases (rheumatoid diseases, pain syndromes, mental disorders and "others", including blindness, paralysis and general weakness) on the other.

Suicide characteristics: (1) year of death; (2) duration of membership in right-to-die organisation; (3) place of death (room owned or leased by the right-to-die organisation, home, institution such as hospital or nursing home, or hotel); (4) prescribing physician (attending physician or family doctor, physician of the organisation); (5) mode of administration (oral, gastric tube/PEG/infusion); and (6) right-to-die organisation.

Data analysis

SPSS V.14 was used for the statistical analysis.[7] Percentages of assisted suicides were calculated for the different sociodemographic and medical parameters as well as for the way in which the suicide was committed. In addition to age groups of the deceased, the mean age and standard deviation were calculated. Student's t test and χ^2 were used to test for statistically significant differences. Taking the "right-to-die-organisation" and "mode of administration" as dependent variables, multivariate logistic regressions were used to analyse possible predictors of suicide assisted by Exit Deutsche Schweiz compared with Dignitas, and of administration by gastric tube/PEG/infusion compared with the oral route.

RESULTS

Number of cases and characteristics of the deceased

A total of 421 cases of assisted suicide were reviewed for the period 2001–2004: 274 (65%) were facilitated by Dignitas and 147 (35%) by Exit Deutsche Schweiz. More of the deceased were women (D: 65%; E: 64%). Those who committed suicide with the assistance of Dignitas were significantly younger than Exit Deutsche Schweiz members (mean age in years (SD): 64.5 (14.1) and 76.6 (13.3), respectively; $p = 0.001$; not shown in the tables) and more likely to be married (D: 40.9%; E: 29.3%). As expected, most (91%) of the people whose suicide was assisted by Dignitas were non-residents: 65% were from Germany, 8% from Great Britain, 7% from France and less than 3% from other countries including Austria (7 cases), Israel (6), Spain, The Netherlands and Australia (each 2 cases). In contrast, most of the suicides facilitated by Exit Deutsche Schweiz were Swiss residents (97%): 88% coming from Canton Zurich and almost 9% from other cantons (table 1).

Concerning the diagnoses, malignancy was the most common terminal condition in both right-to-die-organisations (E: 41.5%; D: 36.5%). Dignitas assisted more people suffering from neurological diseases such as multiple sclerosis and amyotrophic lateral sclerosis (D: 31.0%; E: 12.2%), whilst Exit Deutsche Schweiz was more likely than Dignitas to provide assistance to members with rheumatoid diseases and pain syndromes (12.9% and 7.3%, respectively). On average, Dignitas assisted more persons suffering from fatal diseases than Exit Deutsche Schweiz (78.8%; 67.3%) and fewer people with non-fatal diseases (21.2%; 32.0%), as shown in table 1.

The multivariate analysis shows that age is significantly higher among Exit Deutsche Schweiz deaths than Dignitas suicides, and that Swiss residents are over-represented among Exit Deutsche Schweiz deaths. No significant differences exist between the two organisations for other sociodemographic characteristics and medical diagnosis (table 2).

Committing suicide

During the study period the number of assisted suicides facilitated by Exit Deutsche Schweiz remained fairly constant, whereas the number provided by Dignitas increased during the first two years (2001–2002). Duration of membership was found to be significantly shorter for people assisted by Dignitas than for those who belonged to Exit Deutsche Schweiz. Members for less than one year represented 87.7% and 24.5% of Dignitas and Exit Deutsche Schweiz cases, respectively. Very short membership of less than one week, however, was found to be more often the case for Exit Deutsche Schweiz (<1 week: D: 1.5%; E: 5.4%). Table 3 shows that more data were missing from the Exit Deutsche Schweiz case files than from those of Dignitas (19.7%; 0.4%).

Almost all Dignitas members committed suicide at a flat rented by the right-to-die organisation for this purpose (94.5%) and only 5.1% at home. In one case (0.4%) a hotel room was used. In contrast, Exit Deutsche Schweiz facilitated most of the suicides at the member's own home (61.2%), one third (34.0%) in the organisation's apartment and only a small proportion (4.8%) in institutions such as a hospital or nursing home.

Drugs were usually taken orally (D: 90.9%; E: 75.5%). Table 3 shows that more Exit Deutsche Schweiz deaths followed pentobarbital administered intravenously, by gastric tube or via PEG than those of Dignitas (24.5%; 9.1%). The statistical significance is confirmed by multivariate examination of the relationship between the type of administration and sociodemographic and medical characteristics of the deceased (OR:

Table 1 Number of cases and characteristics of the deceased

	Exit Deutsche Schweiz deaths (n = 147) % (n)	Dignitas deaths (n = 274) % (n)	Total deaths (n = 421) % (n)	p Value*
Sex				
women	64.6 (95)	64.2 (176)	64.4 (271)	0.940
men	35.4 (52)	35.8 (98)	35.6 (150)	
missing	0.0 (0)	0.0 (0)	0.0 (0)	
Age				
⩽44	1.4 (2)	9.9 (27)	6.9 (29)	0.000†
45–64	17.0 (25)	42.0 (115)	33.3 (140)	
65–84	46.9 (69)	42.3 (116)	43.9 (185)	
⩾85	34.7 (51)	5.8 (16)	15.9 (67)	
missing	0.0 (0)	0.0 (0)	0.0 (0)	
Marital status				
single	12.9 (19)	18.6 (51)	16.6 (70)	0.000
married	29.3 (43)	40.9 (112)	36.8 (155)	
widowed	43.5 (64)	22.3 (61)	29.7 (125)	
divorced	13.6 (20)	16.8 (46)	15.7 (66)	
missing	0.7 (1)	1.5 (4)	1.2 (5)	
Origin				
Swiss resident	96.6 (142)	8.8 (24)	39.4 (166)	0.000
non-resident in Switzerland	3.4 (5)	91.2 (250)	60.6 (255)	
missing	0.0 (0)	0.0 (0)	0.0 (0)	
Origin (countries and cantons)				–
Foreign				
Austria	–	2.6 (7)	1.6 (7)	
France	–	6.9 (19)	11.6 (19)	
Germany	2.7 (4)	64.6 (177)	43.0 (181)	
Great Britain	–	8.4 (23)	5.5 (23)	
Israel	–	2.2 (6)	1.4 (6)	
United States of America	–	2.2 (6)	1.4 (6)	
other countries	0.7 (1)	4.4 (12)	3.1 (13)	
Switzerland				
Zurich	87.8 (129)	6.6 (18)	34.9 (147)	
other cantons	8.8 (13)	2.2 (6)	4.5 (19)	
Diagnosis				
malignancy	41.5 (61)	36.5 (100)	38.2 (161)	0.001‡
cardiovascular/respiratory disease	12.9 (19)	10.9 (30)	11.6 (49)	
HIV/AIDS	0.7 (1)	0.4 (1)	0.5 (2)	
neurological disease	12.2 (18)	31.0 (85)	24.5 (103)	
rheumatoid diseases/pain syndromes	12.9 (19)	7.3 (20)	9.3 (39)	
mental disorder	2.0 (3)	3.3 (9)	2.9 (12)	
other	17.0 (25)	10.6 (29)	12.8 (54)	
missing	0.7 (1)	0.0 (0)	0.2 (1)	
Type of diagnosis				
non-fatal illness	32.0 (47)	21.2 (58)	24.9 (105)	0.013
fatal illness	67.3 (99)	78.8 (216)	74.8 (315)	
missing	0.8 (1)	0.0 (0)	0.2 (1)	

*χ^2 test; test without category "missing". †Test for two categories (⩽64 years, >65 years). ‡Test without categories "HIV/AIDS", "mental disorder" and "missing".

5.74; 95% CI: 2.97 to 11.07). People suffering from fatal rather than non-fatal disease were also more likely to use a non-oral route (OR: 8.17; 95% CI: 2.40 to 27.83) (not shown in a table).

Comparison with Exit Deutsche Schweiz data from 1990–2000

In the city of Zurich, 149 suicides were assisted by Exit Deutsche Schweiz from 1990 to 2000, compared with 129 cases in 2001–2004. Due to an increase (from 8.7% to 19.4%) in diagnoses listed as "others", such as blindness, paralysis and general weakness, the proportion of persons with non-fatal diagnoses who were assisted in suicide increased significantly from 22.1% to 34.1%. In 2001–2004, the numbers of women and older people were significantly higher than in the 1990s (women: from 52.3% to 65.1%; mean age in years (SD): from 69.3 (17.0) to 76.9 (13.3), p = 0.000—not shown in the tables); ⩾85 years; from 16.1%; to 35.7%) (table 4).

During the observation period, however, the number of women varied greatly. For instance, they represented 42% in 1994, 92% in 1995, 28% in 1999, 76% in 2003 and 53% in 2004 (fig 1). The proportions of older people and persons suffering from non-fatal diseases showed a steady increase over the 15

Table 2 Predictors for suicide assisted by Exit Deutsche Schweiz (logistic regression, significant odds ratios given in bold)

Independent variables*	OR (95% CI)
Age	
⩽44 (reference group)	
45–64	5.07 (0.75 to 34.27)
65–84	**9.00 (1.42 to 57.18)**
⩾85	**35.20 (4.38 to 283.06)**
Origin	
Swiss resident (reference group)	
non-resident in Switzerland	**0.004 (0.001 to 0.011)**

*Variables not in the equation: sex, marital status, type of diagnosis.

Table 3 Suicides committed

	Exit Deutsche Schweiz deaths (n = 147) % (n)	Dignitas deaths (n = 274) % (n)	Total deaths (n = 421) % (n)	p Value*
Year of death				
2001	23.1 (34)	15.0 (41)	17.8 (75)	0.137
2002	26.5 (39)	24.8 (68)	25.4 (107)	
2003	25.9 (38)	32.8 (90)	30.4 (128)	
2004	24.5 (36)	27.4 (75)	26.4 (111)	
missing	0.0 (0)	0.0 (0)	0.0 (0)	
Duration of membership				
<1 w	5.4 (8)	1.5 (4)	2.9 (12)	0.000
1 w<1 m	7.5 (11)	11.7 (32)	10.2 (43)	
1 m<1 y	11.6 (17)	74.5 (204)	52.5 (221)	
1 y<5 y	12.2 (18)	12.0 (33)	12.1 (51)	
5 y<10 y	9.5 (14)	0.0 (273)	3.3 (287)	
⩾10 y	34.0 (50)	0.0 (0)	11.9 (50)	
missing	19.7 (29)	0.4 (1)	7.1 (30)	
Place of death				
room of right-to-die organisation	34.0 (50)	94.5 (259)	73.4 (309)	0.000
at home	61.2 (90)	5.1 (14)	24.7 (104)	
institution	4.8 (7)	0.0 (0)	1.7 (7)	
hotel	0.0 (0)	0.4 (1)	0.2 (1)	
missing	0.0 (0)	0.0 (0)	0.0 (0)	
Prescribing physician				
attending physician or family doctor	61.9 (91)	6.6 (18)	25.9 (109)	0.000
physician of the right-to-die organisation	35.4 (52)	93.4 (256)	73.2 (308)	
missing	2.7 (4)	0.0 (0)	1.0 (4)	
Mode of administration				
oral	75.5 (111)	90.9 (249)	85.5 (360)	0.000
gavage/PEG/infusion	24.5 (36)	9.1 (25)	14.5 (61)	
missing	0.0 (0)	0.0 (0)	0.0 (0)	

*χ^2 test; test without category "missing".

Table 4 Suicides assisted by Exit Deutsche Schweiz in the city of Zurich from 1990 to 2004

Variables	Exit Deutsche Schweiz deaths 1990–2000 (n = 149) % (n)	Exit Deutsche Schweiz deaths 2001–2004 (n = 129) % (n)	p Value*	Total Exit Deutsche Schweiz deaths (n = 278) % (n)
Sex			0.031	
women	52.3 (78)	65.1 (84)		58.3 (162)
men	47.7 (71)	34.9 (45)		41.7 (116)
Age			0.004†	
⩽44	14.1 (21)	1.6 (2)		8.3 (23)
45–64	18.8 (28)	16.3 (21)		17.6 (49)
65–84	51.0 (76)	46.5 (60)		48.9 (136)
⩾85	16.1 (24)	35.7 (46)		25.2 (70)
Diagnosis			0.220‡	
malignancy	49.0 (73)	45.0 (58)		47.1 (131)
cardiovascular/ respiratory disease	11.4 (17)	10.9 (14)		11.2 (31)
HIV/AIDS	9.4 (14)	0.8 (1)		5.4 (15)
neurological disease	8.1 (12)	9.3 (12)		8.6 (24)
rheumatoid diseases/ pain syndromes	10.1 (15)	12.4 (16)		11.2 (31)
mental disorder	3.4 (5)	2.3 (3)		2.9 (8)
other	8.7 (13)	19.4 (25)		13.7 (38)
Type of diagnosis			0.026	
non-fatal illness	22.1 (33)	34.1 (44)		27.7 (77)
fatal illness	77.9 (116)	65.9 (85)		72.3 (201)

*χ^2 test. †Test for two categories (⩽64 years, >65 years). ‡Test without categories "HIV/AIDS" and "mental disorder".

years (fig 1). This finding also holds true for older men and older women considered as separate groups (not shown).

DISCUSSION

This study is the first to compare the characteristics of members of right-to-die organisations who received suicide assistance during the period 2001–2004, and to examine the practices of two such organisations in Zurich, Switzerland: Exit Deutsche Schweiz and Dignitas. Furthermore, this study investigates whether suicide-related activities of Exit Deutsche Schweiz have changed from the earlier period of 1990–2000.

Dignitas facilitates almost twice as many suicides as Exit Deutsche Schweiz

Compared with Exit Deutsche Schweiz, Dignitas assisted about twice as many suicides in the Zurich region between 2001 and 2004. This difference may be due to the fact that Dignitas provides suicide assistance mainly for non-residents, whilst Exit Deutsche Schweiz offers help only to Swiss residents. Dignitas therefore has a much greater catchment area than Exit Deutsche Schweiz, which assists foreigners only in exceptional circumstances. The annual number of Exit Deutsche Schweiz assisted cases remained steady over this study period while those of Dignitas increased slightly.

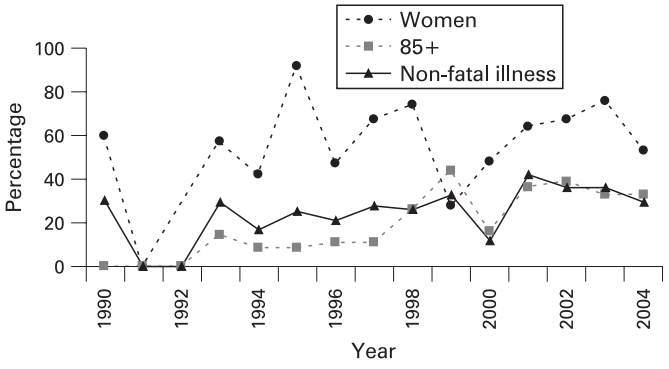

Figure 1 Exit deaths (n = 278).

Dignitas assists younger persons and more who are suffering from fatal diseases

People assisted by Dignitas were significantly younger and more often suffering from fatal diseases than those whose death was accompanied by Exit Deutsche Schweiz. This may be due to the fact that people from abroad had to be fit enough to travel to Switzerland, that is, they were less likely to be older people with multi-morbidity and general weakness.

Most Exit Deutsche Schweiz assisted suicides occurred at home, with medication provided by their own doctor

Research indicates that most people prefer to die at home.[8] This was certainly the case with Exit Deutsche Schweiz members, where the clear majority were able to do just that. With Dignitas, on the other hand, nearly all suicides took place in the organisation's flat. The majority of Exit Deutsche Schweiz members were prescribed a lethal dose of medicine by their own doctors, whereas most Dignitas members obtained their lethal medication through a doctor working with Dignitas. This comes as no surprise given that, in contrast to Switzerland, assisted suicide is illegal in almost all other countries.

Organisation and diagnosis as predictors of mode of administration

The present study found that more Exit Deutsche Schweiz than Dignitas members administered the lethal medication intravenously, via gastric tube or PEG. A possible explanation for this could be a lack of experience in facilitating intravenous administration as Dignitas staff members probably less often have an education in nursing than staff members of Exit Deutsche Schweiz. In addition to the organisation, the diagnosis was also a predictor of the mode of administration: those suffering from fatal diseases were more likely to use an intravenous route. The association between fatal disease and increased likelihood of non-oral administration could be due to terminally ill members experiencing difficulties in swallowing or severe nausea, and the organisation's legal reluctance to use non-oral routes unless the member's condition is fatal. We do not know whether any members requested and used non-oral administration when they were actually capable of swallowing and did not have severe nausea.

More women than men received assistance in suicide

In the present study, the proportion of women committing assisted suicide (almost two-thirds of cases) is higher than that of men in both right-to-die organisations. Previous Swiss studies investigating suicides assisted by Exit Deutsche Schweiz yielded similar results.[6 9] A study on 69 cases of assistance in suicide (49 women) provided by Dr. Kevorkian in Michigan revealed similar differences in euthanasia and physician-assisted suicide.[10] These findings contrast with those from The Netherlands and Oregon where no statistically significant differences in sex for physician-assisted suicide were reported.[11 12]

In The Netherlands, however, more women actually requested assistance in dying.[13] The equal distribution of sex

in assisted dying in this country is therefore the result of the fact that Dutch doctors more often refuse requests from women than from men.[14] This is because they more frequently find signs of depression in the woman asking for assistance in dying. These findings, and the doctors' response to them, correspond to the view that woman are a particularly vulnerable group in assisted suicide,[9 10 15] as depression is generally more common than in men.[16]

On the other hand, the over-representation of women amongst individuals requesting assistance in dying can also be seen in light of the fact that women tend to verbalise their feelings and seek help more readily than men do.[17 18] In addition, the significance of depressive symptoms, as opposed to clear clinical depression, in the assessment of individuals asking for assistance in dying is contested.[13] More research in this field is needed to shed light on the questions of how far it is justified to view all woman as a vulnerable group in assisted suicide, and the extent to which requests from women may possibly be refused because of unwarranted medical paternalism.

Developments of suicides assisted by Exit Deutsche Schweiz in the city of Zurich

In the period from 1990 to 2004, there was an increase in the proportion of women and older people suffering from non-fatal diseases amongst the suicides assisted by Exit Deutsche Schweiz. This suggests that Exit Deutsche Schweiz increasingly accepted more advanced age, multi-morbidity and generally poor health—characteristics more common among women because of their higher life expectancy—as a condition for assisting suicide. However, with regard to the sex distribution, our results demonstrated that the percentage of women was very variable over the 15 years. We are not able to explain this inconsistency on the basis of our data.

It is known from studies on end-of-life decisions in The Netherlands that doctors quite often receive requests for assisted dying from people aged 80 years and over who are not suffering from a terminal illness. However, the Dutch doctors—unlike Swiss right-to-die organisations and the doctors working with them—almost never grant such requests.[13 14] There are several reasons for this, such as "the patient did not suffer from a severe disease and/or the suffering was not part of the medical domain".[13] Based on these Dutch and Swiss results we can assume that Dutch doctors as well as Swiss right-to-die organisations are frequently confronted with requests for assisted suicide from older patients. Finally, we can conclude that in systems where assisted dying is completely dominated by physicians (as in The Netherlands) assistance for older people seems not to be accepted—since it is incompatible with the professional role. On the other hand, in a system where right-to-die organisations play an important role, assistance in dying for older people appears to be considered as showing respect for their self-determination.

Limitations of the study

Information on refused requests for assistance in suicide was not available for analysis so we are unable to determine whether the differences we found relate to the practices of the right-to-die organisations or to the requests they receive. Furthermore, it is possible that some differences between the two organisations are due to dissimilarities in the sources of information, such as the report forms on which personal data and other information on assisted suicides are recorded. These forms were drawn up by the organisations themselves so they are not identical. Moreover, our study was restricted to cases of assisted suicide that took place in the city of Zurich. These results cannot be extrapolated to other regions of Switzerland without reservation.

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